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THE IMPORTANCE OF DIET IN THE TREATMENT OF DIARRHEA IN INFANCY*

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CONTRARY to the general impression a high calory diet can be given to infants suffering from diarrhea without aggrevating the local intestinal condition. While it is admittedly good practice to spare a diseased organ, we should bear in mind that, in diarrhea, the whole intestinal tract is not affected. The affected part is the lining mucous membrane of the intestines and not the tissues concerned with the absorption of the food elements. Consequently, we are under no obligation to spare the portions of the intestinal tract which are not involved in the disease process. On the contrary, we must utilize the absorptive mechanism to its full capacity in order to maintain the patient's general condition at as high a level as possible, so that he may successfully combat the invading organisms. Our problem is to reduce the hypermotility of the intestines. The object in so doing is that the patient may absorb nutriment sufficient for his needs.

In the last few years encouraging reports have appeared regarding the efficacy of the sulpha compounds in controlling some of the intestinal infections. The reports are confusing and often contradictory. However, there can be no doubt that chemotherapy is effective on some occasions and apparently of no value on other occasions. This is not surprising when we realize that diarrhea, in infancy, is not due to any one organism but to a great variety of organisms.

In speaking of epidemic diarrhea of the new born Clifford[1] says: "This syndrome is not a pathological entity, but a miscellaneous group of cases of various etiologies, known and unknown, bound together by a common symptom—diarrhea." The situation in the general field of diarrhea is not dissimilar to that just stated. The etiological factors are numerous.

Owing to the multiple etiological factors in diarrhea, and owing further to the difficulty of identifying these factors, an efficient non-specific form of therapy seems most desirable. The treatment to be outlined is non-specific, simple and effective. I refer to dietary therapy, including the use of apple powder.

Diet has always played a prominent role in the treatment of diarrhea in infancy. Unless the sulfonamides or antibiotics of the future are more effective than is the case today, diet will continue to be of paramount importance in this condition. In the past, the standard procedure has included a reduction of all foods ingested, especially the fats, with an elimination of high residue foods. In most of our medical centres the general principles of treatment do not differ markedly from the above.

This method has never proved entirely satisfactory. The local condition in the intestinal tract was not greatly benefited. The general condition of the patient left a good deal to be desired, since loss of weight or failure to gain weight were inevitable consequences of this low calory diet. It was generally felt, and many today share this point of view, that if the intestinal tract could be spared, or rested sufficiently, the diarrhea would be of short duration.

In pursuance of the two above-mentioned aims, namely: (1) reduction of the food ingested and (2) a low residue diet, I feel we have gone to extremes. I refer to the intravenous therapy so commonly practiced in the diarrhea of infancy. The intravenous treatment supplies adequate fluid intake, the optimum proportion of salts to use in intravenous fluids, is still under discussion. Some effort is made to meet the caloric requirements of the

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infant by the addition of glucose to the salt solutions. Blood, plasma and amino acids add up to a rather lame substitute for the natural selection of foods and minerals normally made by the infant's intestinal tract.

The present day treatment of infantile diarrhea seems to me to be a sort of therapeutic nihilism, since nothing is offered in the way of treatment. It is merely a system of supplying the patient with enough fluids and minerals to keep him alive while he is struggling to cure himself as best he may. In other words, the infant is saved from dehydration and left to recover through the medium of his own natural defenses. However, this is not the whole story. The current method of handling these cases not only gives the patient no direct aid but it actually undermines his only natural defense mechanism, viz: the formation of antibodies, since it deprives him to a great extent of the protein intake from which antibodies are presumably formed.

In this connection let me quote P. R. Cannon:[2] "In as much as experimental evidence indicates that globulin production is dependent upon the intake of amino acids and is impaired by the inadequate intake of dietary proteins, it also follows that antibody production must similarly depend upon protein intake." Further, Wissler[3] et al say: "Evidence has been presented indicating that severe protein deficiency, brought about by a prolonged low protein diet, leads to a marked decrease in the production of antibody."

Now let us consider another method of approach to the problem. Instead of reducing the caloric intake, this method actually increases the intake, with the result that the sick infant receives about 33% more calories per Kilogram than the normal well infant, and from 100% to 500% more than many of the infants receiving the minimal or starvation diets.

A high calory diet, orally administered to infants suffering from diarrhea, rests upon a different philosophy than that of cure through starvation. The infant is losing a large amount of essential food stuffs owing to the rapid passage of material through the intestinal tract. A high calory diet compensates for this loss. The food intake is not reduced, it is increased, in order that an adequate amount of all the food elements, salts and fluid may be absorbed, in spite of the increased peristaltic rate. This is possible because the diminished absorption of food elements, which is characteristic of diarrhea, is due to the rapid passage of the food through the intestinal tract rather than to a diminution of the absorptive capacity of the intestines.

I have used a high calory diet in infants suffering from diarrhea. These infants were from a few days to several weeks in age. Except when persistent vomiting, or severe dehydration was present, oral feeding was found practicable from the outset. Intravenous therapy may occasionally be necessary initially, to correct the above-mentioned conditions, viz: the vomiting or marked dehydration.

The diet used consists of apple powder (appella), boiled whole milk, or evaporated milk and water, in equal parts, one of the prepared barley or wheat cereals, one of the strained meat products, preferably beef, and a multi-vitamine preparation.

There are several features of the above diet which require some amplification. The apple powder is an important component of the regime, since it slows the intestinal rate and converts the watery irritating stools into comparatively normal dejections. Contrary to the usual procedure, the fat content of the diet is not reduced, the sugars, however, are replaced by an equivalent amount of starch. The usual four hour feeding interval is reduced to three hours, in order to increase the caloric intake.

I wish to outline some of the details of management, since they are essential to the success of the treatment. It has been my routine to give one level tablespoonful of apple powder, in three ounces of water, immediately before each milk feeding. This can be given in a nursing bottle, provided the hole in the nipple is sufficiently enlarged. Following this substantial amount of fluid, a feeding of whole boiled milk or one of evaporated milk and water is given. The amount of this milk feeding is governed by the age of the infant and is as large a feeding as would be taken by a normal well infant of corresponding age. One to three teaspoonfuls of strained beef is added to the milk at one feeding and a prepared cereal food at another feeding, vitamines and iron are added in the same manner. I was surprised to find that infants of two or three weeks of age could, with impunity, and would, with eagerness, take this very substantial amount of fluid. No vomiting resulted, no excerbation of the diarrhea occurred. A minor difficulty was noted on two occasions. The entire abdomen was found to be dull on percussion. This proved to be due to an accumulation of the apple powder in the intestinal tract. Omission of the apple powder for two or three days corrected this situation. No ill effects were noted. The apple powder was resumed in somewhat smaller doses without any recurrence of the difficulty.

Such a diet supplies for a four Kilogram infant 150 calories per Kilogram, as well as 5.2 gms. of fat, 4.2 gms. of protein, 5.6 gms. of carbohydrate and 220 cc. of fluid per Kilogram.

I will show some charts which demonstrate the soundness of the postulate that if the intake of food is increased in diarrhea, the absorption of

food will also be increased. These charts show the weight curves of two groups of infants on a minimal or starvation diet and one group upon a high calory diet. The weight gain in infancy is the best single criterion of the progress of an infant, either in sickness or in health, so I have used this as a measure of the relative value of the two forms of treatment under discussion.

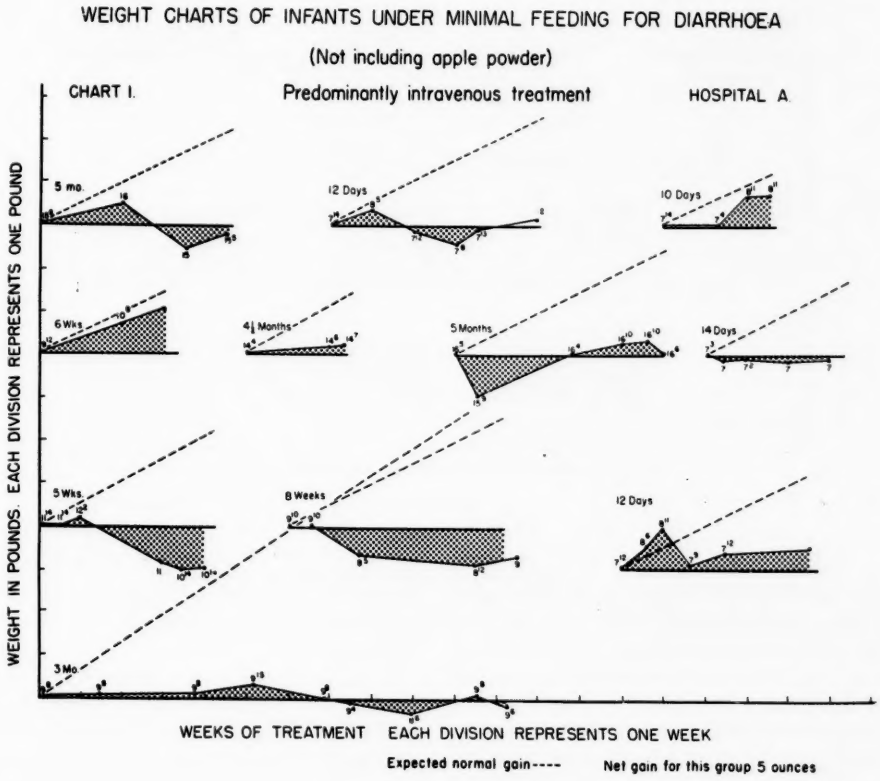

CHART 1

This chart shows the results or the lack of results of the intravenous method of management. The vertical line shows divisions, each of which represents one pound. The horizontal line gives a measure of the time of treatment, each division representing one week. The dotted lines show the expected normal gains. As you will note the expected gains were never realized.

This represents the work of several professors, assistants, residents, internes, social workers, hospital executives, laboratory technicians and a large corps of nurses, ward maids, medical students and by-standers. The work had the approval of a board of hospital trustees, all eminent citizens, selected owing to their ability to raise or to leave money for the benefit of the hospital. Unfortunately none of the latter group knew anything about managing a hospital.

This work was done with a background of marble and brick, starched uniforms and profound airs. Unfortunately for the patients and their parents none of the paticipants in this opus had ever practiced medicine outside of a hospital. Many chemical analyses, bacterial studies and other laboratory procedures too numerous to mention, added to the confusion and to the expense, which was not inconsiderable, in view of the very modest end result of all this effort. When the smoke cleared away this formidable group knew all about every part of the child, but, as the chart shows, they didn't know too much about the child as a whole.

The infants treated in Hospital A spent 350 days in the hospital at approximately $10.00 a day. So you can see that to assemble this armada of workers about this group of sick infants cost $3,500.00, the net gain for the group was 5 ounces. Cost per ounce of gain was $700.00!

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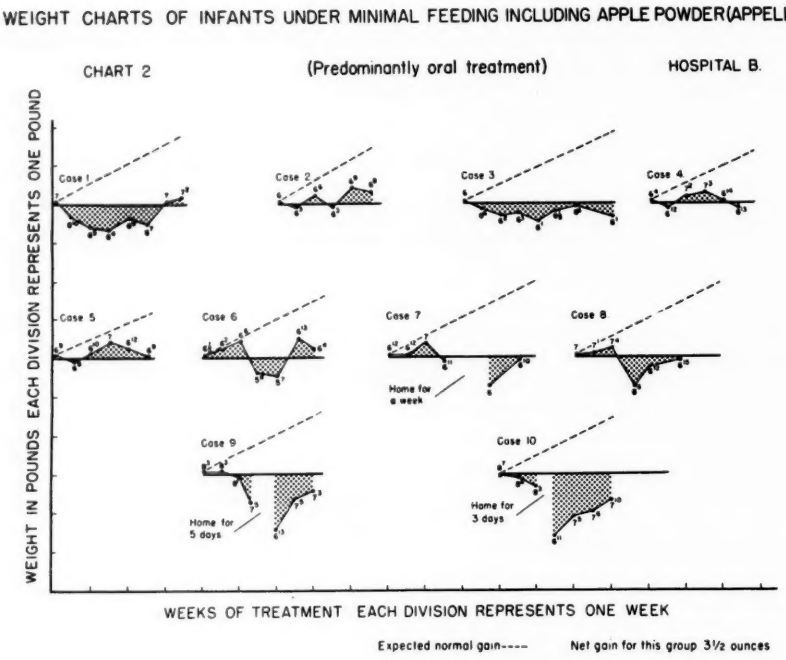


CHART 2

This is also a hospital group. Some intravenous therapy was used but the oral method was predominant. The feeding was minimal. The caloric intake was well below the requirements of a normal infant and far below my idea of the requirements in diarrhea. The results are far from satisfying. The net gain for this series was three and one-half ounces. The cost of care for the whole group was approximately $2,415.00, making the cost per ounce of gain $690.00.

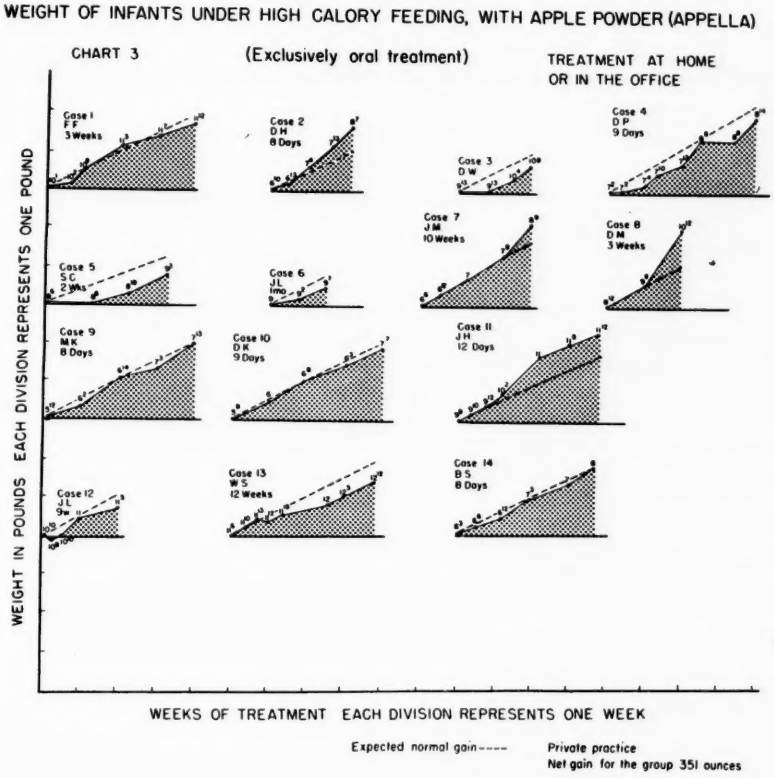
CHART 3

The third chart represents what was done in private practice by one physician without assistants, hospitilization or complicated laboratory procedures. The feeding was exclusively oral. Apple powder was used in conjunction with a high calory diet. The expected gain was usually approximated and at times was exceeded. You will recall that the net group gain in the first hospital series was 5 ounces, in the second hospital group the net gain was 3½ ounces. The net gain in the private practice group reached the amazing figure of 351 ounces, seventy times as many ounces as were produced in one of the hospital groups and one hundred times as many ounces as were recorded for the second hospital group! The cost of care for this group was $660.00, which includes the physician's fees and an allowance of $10.00 a week for food and medicines. The cost per ounce of gain was $1.90. When this figure is compared with the hospital costs of $700.00 and $690.00 per ounce, the question arises as to how long the hospitals can stand competition of this sort.

The almost unbelievable discrepancy between the results and the cost of the hospital series and the results and cost of the series in private practice may well raise the question of whether or not the comparison is fair. I believe it is. Each of the hospital series is composed of cases which arose within the hospital walls during an epidemic of diarrhea. Each series was unselected. This is mentioned to remove any impression that the hospital series were composed of difficult cases received from private physicians. This is not the fact. Each series represents all shades of severity; each series is composed of unselected cases. Likewise, the cases from private practice were unselected, "run of the mine" cases.

Support of the above observations appears in recent work of Chung and Holt[4]. They found in a study of infant diarrhea that a liberal diet, as compared to a minimal or starvation diet, resulted in an increased absorption of the total ash, water, sodium, potassium, calcium, chloride, fat and nitrogen.

The high calory oral feeding of infants with diarrhea is much superior to the starvation or minimal feeding so commonly practiced, in that the natural defenses, viz: the antibodies are given an opportunity for full development and full



functioning. The extra calories supplied compensate for the food lost owing to the accelerated intestinal rate which occurs in diarrhea. Its simplicity of administration further recommends it in contrast to the laborious, expensive and highly artificial intravenous method. It is also superior to the minimal oral feeding, which reproduces to a lesser degree the faults of intravenous management. The long standing practice of reducing the diet in diarrhea is based upon the premise that the entire intestinal tract is affected by the disease. I feel that this is a false premise since the absorptive function is clearly unimpaired as demonstrated by the normal weight gains shown in the group given a high calory diet.

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LEGAL HAZARDS OF THE PRACTICE OF MEDICINE*

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MY TALK this evening is designed to be of practical use to doctors who are engaged in active practice. It is not intended to be a learned treatise on the intricacies of the law of negligence with special reference to the law of malpractice. It is, however, an attempt to examine realistically the legal hazards to which the profession is necessarily exposed and to offer suggestions which, if followed, will reduce such hazards.

Admission to practice, conferring, as it does, a high personal privilege, necessarily carries with it certain well defined and serious obligations to the individuals whom you undertake to serve. I think it will be advantageous at the outset to review them and state them.

First: You represent to every patient whom you treat that you possess that degree of learning and skill ordinarily possessed by physicians (or surgeons, as the case may be,) of good standing who are practicing in this state.

Second: You undertake to exercise reasonable care and diligence and to use your best judgment in treating the patient.

I am sure you will understand me when I say that any suggestions that I may advance will assist only doctors who discharge the above obligations. If you have not become qualified and careful through your training and your practice, I am sure I can not improve your lot by talking to you. I am concerned with competent and conscientious doctors who get into legal difficulties by failing to safeguard themselves. In order to take the necessary precautions, however, a complete understanding of these obligations is necessary and in this connection the following statements are pertinent:

1. No duty is imposed on a physician to accept employment, and a doctor's refusal may be completely arbitrary. In other words, you are licensed to practice, and not compelled to.

2. As to charity cases, you do not have to accept them, of course, but when you do accept and treat them, you owe them the duties which I have mentioned.

3. These duties may be increased by contract, but failure to perform the extra duties will be only a breach of contract and will not be a tort. The only substantial difference would be that in an action of contract damages for death can not be recovered, nor can punitive damages. The Statute of Limitations is six years in a contract action and only two years in tort.

Now how do we apply the standards defined by the above duties? The law takes as its standard the "average physician." A doctor after an unsuccessful treatment may say with all honesty: "I did my best." This is, of course, not the standard. This is a subjective test and that of the law is objective. This works, however, both ways, because in the case of a doctor possessing skill and diligence above the average, the subjective standard would be higher than the legal one.

The short answer to the question propounded is that in the average suit for malpractice a jury decides upon the testimony of qualified physicians what the standard is and whether or not the doctor has met it. There is the one great hazard from which many little hazards stem. In the final analysis you will be judged by laymen.

This necessitates the marshaling of facts in easily understandable fashion and it also indicates careful attention to practical considerations which weigh more heavily with laymen than with the profession. I shall discuss briefly those which I consider most important from a jury's point of view.

1. A vital matter in any malpractice suit is the existence of a full and persuasive set of records, records which convey the impression that the treatment given has been scrupulously careful. Ideal records should be kept in every case. They should record the complaint, the symptoms, the diagnosis; they should record clearly what was done, what advice was given; they should show that nothing was neglected and that the law's standards were complied with.

If any patient refuses or neglects to follow advice, this should be noted. In a case of a disobedient or uncooperative patient, it is well to write him a letter pointing out the possible consequences of his

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unwise course and keep a carbon copy in his file. If good records are kept, the facts contained in them will very seldom be assailed successfully, and in a majority of cases a good record is the best defense. Conversely, a poor record may be a damning indictment.

2. Because in the final analysis you may be judged by laymen, the matter of tact in handling patients is important as well as professional ability. A professional manner and attitude has a considerable effect. It forestalls criticism and engenders confidence. And if you see signs of a failing confidence when things are not going well, in the patient or his family, a very great protection against a malpractice suit is the consultation. If this is timely done, and if your treatment has been adequate, you will be practically impregnable against an unjust claim which ignorance and disappointment may subsequently produce. All of the implications are turned in your favor. It is implicit in demanding a consultation that you were being diligent; it negatives that kind of professional conceit, the self-sufficiency of which is not popular with a jury; and you are securing in a friendly colleague excellent corroborative testimony.

3. I next suggest that it is wise to refrain from over-optimistic prognosis. Disappointment which ensues adversely affects the patient's state of mind and it is in the mind of the patient that the malpractice suit is born. This type of prognosis can be harmful before a jury because, if proved, it becomes clear that the doctor was wrong as to one thing and it then becomes easier for a jury to find him wrong in others.

4. I also think that a word of warning is in order on the subject of what I call "loose conversation." Impulsive "off the cuff" remarks are all too often taken as admissions of guilt and these can be devastating. I shall never forget a case that I tried many years ago (the doctor involved has since deceased) in which one of the worst things with which I had to contend was one of those admissions. In that case a fractured ulna was diagnosed and the patient was sent to an X-ray man where pictures were taken showing arm and elbow. The X-ray report to the physician showed a fractured ulna, nothing more. Weeks later it was discovered that there was also a dislocated radius at the elbow and the doctor was reported to have exclaimed: "Well, that's my fault. I should have found that."

Not a single physician could be found by the plaintiff who would testify against the doctor. Upon receipt of the X-ray report he had acted precisely as he should. The fault, if any, was in the X-ray report. But on the testimony of that admission the case was submitted to the jury, who fortunately exonerated the doctor. They were nine to three, however, for several hours, and I know perfectly well that if the doctor had not been so careless in his talk, he never would have had to endure the ordeal.

5. There is another kind of personal conduct indulged in by doctors which is probably responsible for about seventy-five per cent of all the malpractice cases that are instituted, namely, criticism of other doctors. If a patient is dissatisfied with his progress, changes doctors, that is, of course, something he has a perfect right to do. But when the new doctor upon examining him, remarks, "What horse doctor have you been going to?" or even turns a more subtle phrase, you have a perfect setting for a suit. The patient's state of mind is thereby perfectly conditioned for litigation. He immediately considers himself aggrieved and he thinks, of course, that in his new doctor he has the means of proving his grievance. That his new doctor will, when pressed, emphatically deny the statement (which is usually what happens) never occurs to him. It never occurs to him, either, that his new doctor seeing the case for the first time is probably in no position to pass judgment on previous treatment, at least without consulting the former doctor. But the damage is done and I am personally convinced that most cases are prompted by that loose form of criticism.

The matters discussed above are the kind that count when you are before a jury and they are matters that can not be adjusted to suit your purposes after the suit has been instituted. They are considerations that must be foremost in your mind in each day's work, because you never know in advance which case is going to be the source of this particular type of trouble.

There are other routine precautions which I am sure every doctor knows but which might be mentioned. They speak for themselves and need little comment:

(a) Procure written consents for operations.
(b) Be careful that your assistants are intelligent and qualified. As to duties you delegate to them, you will be responsible.
(c) Accept only patients whose ailments are well within your field of practice.
(d) Check the condition of your equipment frequently.
(e) If you are going away, make suitable provisions for the care of your practice.
(f) When you examine female patients, have a third person present, if possible.
(g) Finally, never let your patients know that you carry malpractice insurance.

So far, I have had in mind, the usual malpractice case in which no recovery can be had against a doctor unless some other doctor testifies in court that his treatment was below the standard required

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by the law, that is, the standard of the average physician in the locality. I think I should point out, however, that there are cases in which a doctor can be sued successfully without any medical witness appearing against him. These are cases where the legal doctrine of *res ipsa loquitur,* (the thing speaks for itself) is applicable. The classic example might be put as follows: the plaintiff passing the defendant's brick building, on the roof of which defendant's employees are repairing a corner of a wall, is struck by a falling brick. These facts being shown, negligence on the part of the defendant is inferred and the burden is on the defendant to introduce testimony showing him free from negligence.

The doctrine has been applied to professional treatment in the following types of cases:

(a) sponges left in after an operation;

(b) slipping instruments; and

(c) burns from heating apparatus.

You can see that it is reasonable to require some explanation of these occurrences. I have had all three types (that list by the way is not exclusive) and I must say that I have never yet been able to devise an adequate explanation for the presence of sponges in a wound after an operation. An instrument conceivably may slip due to some outside cause and may be capable of explanation. A burn sustained by a person in full possession of sensations may not be indefensible because the fault may be the patient's for failure to complain; but the sponge in the wound is really difficult.

Passing by the obvious observation that these things should not happen, when they do happen, repair the damage as well as possible and get a report in to your insurance company or your lawyer and get the case adjusted, if possible. Cases of this nature should not be tried in court if such trial can be avoided by a reasonable settlement.

I mention this class of cases because they have been growing in recent years and there is an unpleasant tendency to enlarge the doctrine of *res ipsa loquitur.* Carried to the extreme it would mean that in every case where there was a bad result, a physician would be called on to explain why it was bad, without any negligence being proved against him.

There is another class of cases which I think merit special mention and in which the law is in some slight confusion. I refer to cases of sterilization.

As to nontherapeutic sterilization I can not conceive of any legal argument than can ever justify it, whether or not you have the consent of the patient and the patient's spouse. Nontherapeutic sterilization contains all of the elements of the crime of mayhem. It involves an intentional wounding, the severance of an organ and the destruction of a bodily function, none of which is necessary for the health or well being of the patient, and the result of which is to deprive the state of the reproductive facilities of one of its citizens, in which the state has a definite interest. Clearly, consent can not be given to a crime, and I am forced to the conclusion that nontherapeutic sterilization is a dangerous undertaking no matter how many consents you have.

As to therapeutic sterilization, however, assuming you have the consent of the patient, do you also need the consent of the spouse? Of course it is nice to have it, but if in some rare instance it is not forthcoming, why should you jeopardize the health of your patient? If a woman consented to the amputation of her gangrenous foot, which you recommended, would you refrain from operating because her husband objected? By all means obtain the consent of both wherever possible, but if you have a case where sterilization is clearly indicated for compelling reasons of health, I can not see why a spouse should be able to prevent it, if the patient consents.

Statistics pertaining to the number of malpractice cases instituted throughout the country are not, so far as I know, available in any accurate form. It is quite clear, however, that in the last two decades the growth of this type of case has been substantial. If we take as an index the number of cases reported in Appellate Courts, that is, cases that have gone to the Supreme Court of the various states, we find that one-third of all cases prior to 1940 were decided between 1930 and 1940. The problem, therefore, is a growing one, and it will be solved only by the affirmative action of professional groups. That action must take the form of a purposeful, educational campaign directed to every member of the profession designed to teach him to take care of himself. This can be done if the profession will acquire a thorough knowledge and understanding of its obligations, if it will develop the habit of attending scrupulously to the performance of those obligations and if it will have the common sense to take the precautions that I have mentioned.

LYMPHOID POLYPOID HYPERPLASIS OF THE RECTUM*

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Introduction

THE occurrence of lymphoid tissue in the rectum is a well documented fact. It occurs frequently as solitary follicles, with well defined germinal centers, arising in the submucosa. Much more infrequent has been the report from time to time of rectal polyps which, for all practical purposes, are grossly indistinguishable from the ordinary rectal adenomatous polyp, but which on microscopic examination are found to be composed of collections of lymphoid tissue, hence the name lymphoid polypoid hyperplasia. It is the purpose of this paper to describe four such cases seen by us at the Institute of Pathology within the Rhode Island Hospital in the space of four months. Recognition of this condition is important since histologically it may be confused with malignant lymphomas.

Case Histories

1. The patient, D. M., is a 47-year-old white female admitted to the Rhode Island Hospital on April 27, 1949, who developed rectal bleeding, rectal itching, and constipation one month prior to admission. The blood was bright red and occurred as streaks on the surface of stools. On rectal examination a nodular area was felt at 6 o'clock. On proctoscopy this was described as a polypoid lesion, the pedicle of which could not be visualized, and which measured 2.5 cm. in diameter. This was covered with smooth mucous membrane. This polypoid lesion was biopsied and removed following the receipt of the pathological report.

2. The patient, E. W., is a 35-year-old white female who was seen in the Cancer Detection Clinic at the Rhode Island Hospital on February 25, 1949. There were no symptoms. Rectal examination, however, revealed a small polyp on the left posterolateral wall of the rectum. At operation a hard, sessile polyp, measuring 0.5 cm. in diameter and located about 9 cm. from the anus, was removed.

3. The patient, A. G., a 31-year-old white male, was admitted to the Miriam Hospital on January 21, 1949, with the chief complaint of slight bleeding from the rectum of nine years' duration. For a few months prior to admission, bleeding had become more frequent and more pronounced. On rectal examination internal hemorrhoids and two rectal polyps were noted. Of the two polyps, one was on a long stalk. The polyps were excised and hemorrhoidectomy was performed.

4. The patient, M. K., a 39-year-old white female, was admitted to the Memorial Hospital, Pawtucket, on March 9, 1949, with the chief complaint of bleeding from the rectum at irregular intervals for sixteen years. There had been several profuse hemorrhages. On rectal examination there were large external hemorrhoids in the anterior wall as well as a small polyp. The polyp was 1 inch in length and located 2 inches from the anorectal line anteriorly. It was removed with the hemorrhoids.

Pathology

Of the five polyps removed in these four cases, two had a broad base, one was attached by a thin stalk, and in two the base was not mentioned. Each was covered with smooth, pinkish gray, glistening mucous epithelium. In no case was their gross appearance characteristic of anything besides an adenomatous polyp.

Microscopically, these polyps in each case presented a similar picture. Sections revealed marked lymphoid hyperplasia of the submucosa with consequent polypoid elevation of the overlying mucosa. The cytology of the lymphocytes did not appear abnormal; the nuclei were dark, the chromatin coarsely granular, and the cytoplasm clear and sparse. The lymphocytes were arranged in numerous discrete follicles, with active germinal centers, showing phagocytic activity. The lymph follicles were of variable size, at times quite large, and in many instances of irregular shape. In addition, there was moderate lymphocytic infiltration of the mucosa to a varying degree.

Discussion

From time to time papers have appeared in the literature describing the occurrence of these polypoid tumors of the rectum, which have been classed as lymphoid polypoid hyperplasia. In 1948 *Li* briefly tabulated twenty-three cases reported since 1890 and added twenty-six others. Since then *Hel-*

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*From the Institute of Pathology within the Rhode Island Hospital. The authors acknowledge with thanks the permission of Drs. Edward V. Famiglietti, Thad A. Krolicki, Daniel V. Troppoli, and Eske K. Windsberg to report these cases.

wig reported on seventy cases from the Army Institute of Pathology and *Heller* reported nine cases. These lesions, therefore, while not common, are undoubtedly not as rare as their absence from the standard textbooks would lead one to believe.

The nature of these lesions is invariably not at first suspected; their symptom complex does not differ from other common rectal lesions, and their gross appearance closely simulates adenomatous polyps of internal hemorrhoids. It is not until microscopic sections are taken that their lymphoid nature becomes apparent. As has been stated, lymph follicles are commonly observed in the rectal submucosa, and it seems logical to assume that the lymphoid accumulations we are observing are derived from these follicles. In each case, however, the important consideration is whether this multiplication of lymphoid tissue is a malignant or benign process. In the present series of cases we are impressed by the tendency to phagocytic activity of the cells within the follicle, the finding of follicles with germinal centers, and the focal nature of the lesion. The lymphoid tissue is, for the most part, limited to the submucosa and mucosa. In addition, both small and large lymphocytes are intermingled. These are features which are more consistent with a chronic inflammatory condition.

Our own feeling, therefore, is that these polypoid structures are a response to chronic inflammation with resultant lymphoid hyperplasia. This increase of lymphoid tissue has produced elevation of the mucosa with consequent polyp formation. Lymphoid polypoid hyperplasia is therefore a benign condition, and with removal no further sequelae need be anticipated.

In conclusion, however, we feel it necessary to point out that in certain cases the differentiation from the malignant lymphoma group may be extremely difficult, and that in these cases the best interest of the patient will be served by a careful program of postoperative observation.

Summary

Four cases of benign lymphoid polypoid hyperplasia are presented. This condition grossly resembles rectal polyps, and microscopically is composed of lymph follicles. The condition is benign, and is believed to represent an inflammatory condition. It must, however, be carefully differentiated from the malignant lymphoma group.

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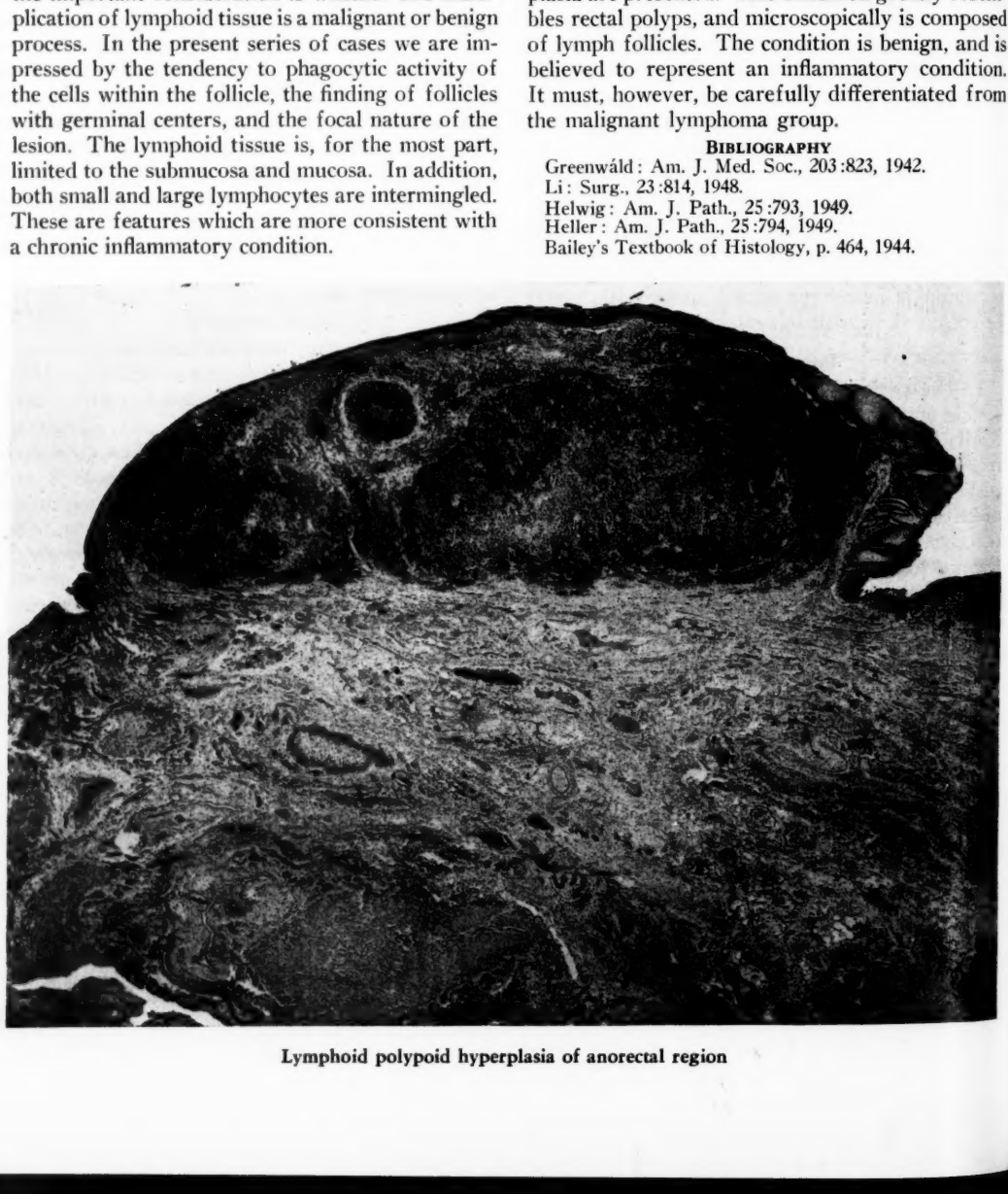

Lymphoid polypoid hyperplasia of anorectal region

SKIN IRRITATION AROUND THE ANUS DUE TO AUREOMYCIN

HENRY L. C. WEYLER, M.D.

The Author. *Henry L. C. Weyler, M.D., of Providence. Visiting Physician and Associate Cardiologist, Rhode Island Hospital; Cardiologist, Providence Lying-In Hospital.*

ATTENTION is being called to a complication that occurs with the use of Aureomycin that is not generally recognized as being caused by this drug. During the past year, a number of patients have been observed who received Aureomycin for various types of illnesses, including virus pneumonia, colds, chronic undulant fever, and genito-urinary tract infections. Those cases which originally had gastro-intestinal disturbances, such as colitis and diarrhea, are purposely being omitted so as not to confuse the cause of the findings that are described.

About a week or ten days after beginning the use of Aureomycin (in some cases sooner), a number of people develop redness, irritation, itching, and fissure formation around and into the anus. In some, the irritation extends down the thigh a short distance and/or down to the scrotum. This may last from a few days to several months having a tendency to almost disappear only to recur again a few days later. There may be a loss of superficial tissue with "weeping" or wetness. Some patients scratch themselves until they bleed.

The size of the dose does not seem to be important. 250 mgs. every 8 hours for 3 or 4 days is sufficient to cause trouble.

Associated with the above condition around the anus, the patient may complain of soreness of the rectum and general gastro-intestinal disturbances, such as excessive gas, rumbling of the intestines, or diarrhea. These complications have been described before by others.

The patient, for some reason, does not always tell the doctor about the irritation around the anus. Possibly he believes it is something that will soon go away or he is embarrassed. He never seems to associate it with Aureomycin. Therefore it is often necessary to ask direct questions about these symptoms. The complication is very frequent. However, I cannot give an exact percentage of the cases involved.

The cause of the skin irritation described above is not clear. Two explanations are being offered: 1. allergy, 2. a changed intestinal bacterial flora. Aureomycin ointment was used on such an inflammatory area in one patient and the condition was not made worse. If anything, it appeared to help. This would seem to rule out allergy due to the drug as a direct cause of the reaction. Moreover, antihistamine ointment did not help much. Changed bacterial flora could cause an allergic reaction in itself, or an irritation due directly to bacterial products.

Various types of ointments have been tried but none of the usual simple ointments have done very much good, except to give some immediate relief. As time went by, the patients showed less severe recurrences.

This complication can persist for a long time and cause a great deal of discomfort.

DIABETES DETECTION WEEK — 1949

Report of the Committee on Diabetes of the Rhode Island Medical Society

It is estimated that there are over a million undiscovered diabetics in the United States. The American Diabetes Association in cooperation with the State and County Medical Societies, is attempting to find these diabetics so that early treatment can be advised. To accomplish this, the week of October 10th through the 16th, 1949, was designated as Diabetes Detection Week. At the suggestion of the American Diabetes Association, the President of the Rhode Island Medical Society, Dr. Joseph O'Connell appointed a Committee on Diabetes in the Spring of 1949 to study the subject and to cooperate with the national organization in this work.

The Committee met on several occasions, formulated plans, and to the best of our ability these plans were set in motion.

Every Physician in the State Medical Society was contacted by letter and his cooperation enlisted. Letters were also sent to all physicians engaged in industrial work requesting that all employees under their care be checked for glycosurea and that the results be kept confidential. The Hospitals in the State, the Health Departments in the State and private laboratories were contacted and their cooperation obtained. In addition we were fortunate in enlisting the cooperation of the District Nursing Associations, various civic organizations, the Department of Education, some of the private schools, the press and the radio. The drug stores acted as collecting stations. The radio stations made spot announcements and the Providence Journal-Bulletin had an editorial and several articles throughout that week, including endorsements of the drive by the Governor and the Mayor.

The Ames Company of Elkhart, Indiana, donated 1,000 Clinitest Tablets free of charge. The Medical Society furnished material to schools, industrial plants and Nursing Associations requesting them.

Everyone in the State was offered the opportunity to be tested for glycosurea. The examinations were made gratis as a public service by the physicians, hospitals, health departments and private laboratories throughout the State.

The response was very satisfactory. The overall number of tests made was 7,320; number of positives 319, or 4.35%. The number of blood sugar determinations was 31. Patients found to have glycosurea were advised to contact their own physicians; industrial plants kept their reports confidential so as not to jeopardize the jobs of employees found to have diabetes.

The Committee wishes to make the following recommendations:—(1) That the Auxiliary of the Rhode Island Medical Society take an active part in future drives. That it assume responsibility for some of the publicity essential for the success of the drive by arranging talks before Parent-Teacher organizations, etc., and (2) That each County Medical Society appoint a Committee on Diabetes, the Chairman of which shall attend all meetings held by the Committee on Diabetes of the Rhode Island Medical Society, and to work in close cooperation with ur Committee.

We feel that Diabetes Detection Week has been a real service to the public and that it is a step forward in improving the relationship between the medical profession and the general public.

Our sincerest thanks to all who made this week a success; the Governor, the Mayor, the medical profession in general, private laboratories, hospitals, health departments, the Providence Journal-Bulletin, local radio stations, and last but not least, Mr. John Farrell who gave so willingly of his time and experience which contributed so much to the success of the drive.

COMMITTEE ON DIABETES,
RHODE ISLAND MEDICAL SOCIETY

Louis I. Kramer, M.D., *Chairman*

James H. Prior, M.D. — Alex M. Burgess, M.D.
Louis E. Burns, M.D. — Edwin B. O'Reilly, M.D.

The RHODE ISLAND MEDICAL JOURNAL

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REHABILITATION

REHABILITATION, a Mediterranean word, comes to us from the jurisprudence of the Middle Ages. To the medieval civil and canon lawyers, *rehabilitare* meant the act by which a man was restored to his former ability, of which he had been deprived by a conviction, sentence or judgment of a competent tribunal. Rehabilitation, therefore, denoted the *restoration* of something of which a man had been deprived, his good name, his status, his fortune, or his property. As in olden times, so today, when we speak of rehabilitation, there is implicit always in our meaning the idea of restoration. Indeed, so popular has the word become that we talk of rehabilitating the soil, our criminals, our finances and, on occasion, even literary reputations and political parties.

To us physicians the practice of medical rehabilitation is nothing new, although the word itself is a relatively recent addition to our vocabulary. From the earliest days of our craft, and because of it, we have always labored to rehabilitate our patients. As a practical art, medicine has ever been directed to the restoration of health, which means the "wholeness" of those committed to its care. The march of knowledge and the improvement in techniques have but widened our efforts and made them more effective over a wider field of endeavor—that is all. In our day we are required to participate in the solution of those multifarious and increasingly serious medical problems which are the inevitable concomitants of life in our industrial society. Whereas, for the most part, our forefathers in medicine were constantly at war with the ubiquitous microbe, we are confronted not by the microbe only, but by the ubiquitous machine.

Unless our attention has been directed particularly to the subject, few of us, perhaps, realize how vast is the army of those who need and desire rehabilitation. Drs. Howard Rusk and George G. Deaver have recently reminded us of some startling and sobering facts of which the following are a mere sample. The Baruch Committee on Physical Medicine estimates that there are 23,000,000 persons in the United States who are handicapped by reason of disease, injury, maladjustment or former wars. One person out of every 20 is disabled by sickness or accident in any 24-hour period. There were 19,000 amputations during the last war; in the same period there were 120,000 amputations in the civilian population. Approximately 1,500 service men lost their sight; during the same period 60,000 civilians were blinded. During the late war, 265,000 men were permanently disabled; in the same period, 1,250,000 men were permanently disabled in civilian life. It is estimated that there are 7,000,000 persons in the United States who are disabled by diseases of the heart and arteries; 360,000 by rheumatism, and over 2,000,000 by orthopedic troubles. In 1946, 10,000,000 disabling accidents occurred in this country, and of these, 370,000 resulted in permanent disability. There were 90,000 workers in the United States perma-

nently disabled because of industrial illness and over 2,000,000 other workers disabled temporarily. It is estimated that the total time lost by these men is equivalent to that of 1,000,000 workers kept out of work continuously for more than a full year. Again, it is estimated that spinal injuries alone cost the railroads of the United States approximately $50,000,000 annually and that $25,000,000 of this amount represents waste due to ineffective treatment.

Aside from the incalculable toll of suffering, unhappiness and domestic disintegration resulting from these conditions, the economic loss is tremendous. Faced with these irreducible and stubborn facts, it is not surprising that there is a growing interest in and demand for rehabilitation on the part of physicians and the general public, in a word, on the part of all those who are intent upon reducing this mass of misery.

Naturally, the purpose of rehabilitation is to make people self-supporting within the limits of their disabilities. There are many reasons, economic, social and spiritual, why it is desirable that the handicapped should not be totally dependent upon others. They, themselves, desire self-sufficiency; and the fact that they may attain this is evidenced by the work of the Federal Office of Vocational Rehabilitation. During the fiscal year 1949, 58,000 persons were rehabilitated. Seventy-four per cent were unemployed at the beginning of rehabilitation; 100 per cent had jobs when it was completed. The wages paid to these people reached $94,000,000, or almost 5 times the previous earnings of the entire group.

It should be remembered that the expense of vocational rehabilitation is not a continuing burden upon tax-payers. Once it is paid, the cost becomes merely a matter of history. What continues is the increasing economic worth, the improved wage- and salary-earning power of the beneficiaries. The gain in morale, of course, cannot be measured. It cannot be shown in statistical tables and charts and is best appreciated by those who are the recipients of rehabilitation.

Medicine has always been an individualistic profession. Indeed, it is about the only remaining individualistic profession in a cooperative world. But that successful rehabilitation is not a job for the physician only, should be obvious to anyone who gives the subject serious consideration. It requires, and should receive, the cooperative assistance of many people endowed with a variety of skills and experience in many fields; in a word, it demands team-work. In this team-work the physician should play an important part, for, to him, the sick and the injured look for help and guidance.

No man can be said to be fully rehabilitated until he is restored to the enjoyment of all the abilities he may possess. Too frequently, it happens that he is only partially rehabilitated when he is discharged from the hospital or leaves the office of the private practitioner. To stop rehabilitation at this point is to leave the job but half done; and it is becoming obvious already that the interest of physicians in rehabilitation, if somewhat tardy, is nevertheless increasing and that in the not distant future, they will take their place as leaders in this field of therapeutic endeavor.

POLLUTION

Corrupt and contented may have described the physical and mental attitude of Rhode Island a few years ago. Our waters stank, our shellfish died or were not fit to eat, much of our great bay was too nasty for respectable people to disport themselves there; smoke belched from most of our chimneys, obscuring the sun, discoloring the paint of our buildings almost as fast as it could be put on, begriming the inside of our habitations and the outside of our bodies, and slowly choking our foliage.

Few of the inhabitants seemed to be disturbed by this. Before the war a committee on water pollution tried valiantly to get some action but apathy defeated them.

Several years ago the Providence Medical Association appointed a committee on water pollution, later changed to a Rhode Island Medical Society committee. This Journal discussed the matter and public opinion began to bestir itself again. A new and active Pollution Abatement Committee of Rhode Island was formed, and the gentlemen at the State House got interested.

Things really are looking brighter now. Pictures and stories are appearing in the daily press telling of improvements.

Today we received from Harvey Flint, the Chairman of the Information Committee of the Pollution Abatement Committee of Rhode Island, a short word picture of the situation.

Woonsocket hasn't done much.

The Blackstone Valley authority is making great progress with $5,000,000 contracts let.

East Providence has voted to borrow $2,700,000 and construction will start in a couple of months.

Providence's million dollar disposal plant will be operating in two months and 60 million gallons a day of decent effluent will go into the bay instead of that much sewage.

Warren will be operating a modern plant by summer.

Bristol is fair.

continued on next page

We had quite a run in with the navy a year or two ago and they didn't like our mention of their nastiness. The Senate last week passed a bill for $1,234,000 for sewage disposal. Here's hoping.

Newport is expected to follow the Navy example.

Jamestown hasn't started yet.

Westerly is doing well but their Connecticut neighbor, Pawcatuck is dumping raw sewage. That's not neighborly.

East Greenwich isn't doing right by their quahaugs.

Pawtuxet River and Cranston are free of brewery waste and have stopped stinking.

The State Institutions will be handling their sewage properly by summer.

Industrial sewage from North of Providence is receiving attention. If more plants follow suit we may go through Market Square without clothes pins on our noses.

This really makes cheerful reading.

For several years the Providence Medical Association has had a committee on Air Pollution. These men have worked hard in cooperation with other citizens and although not a great deal of concrete results have arisen as yet, a basis for good work has been laid down.

The city now has an Air Pollution Engineer and we are hopeful that we will be able to go ahead as other cities have done.

St. Louis and Pittsburgh are striking examples.

It has been the feeling of those interested in this matter that the problem is more than a Providence one, and therefore, the Providence Medical Association committee is discontinuing its work which will be taken over by a committee of the Rhode Island Medical Society. There is a list in this issue of the committee appointments.

We are sure that the medical profession has been a great help in both these works, and we pledge our continued support.

MEDICAL-DENTAL SEMINARS

We are publishing in this issue of the Journal the program of the Medical-Dental Seminar which is to be conducted soon by the Rhode Island State Dental Society at Providence College. This is a continuation of the excellent work started last year when this same Society had a series of six lectures at Brown University given by eminent visiting physicians. Last year's lectures were received enthusiastically by a goodly number of dentists and we believe a smaller but appreciative group of physicians.

This work is highly to be commended and it has received the most genuine praise from our neighboring state of Connecticut. That is—they are imitating it. There is going to be this month a program at New Haven consisting of five lectures on mouth conditions. These lectures are sponsored jointly by the Connecticut State Medical Society and the Connecticut State Dental Association.

Probably in the past the average dentist has not known a great deal of general medicine and it is probably just as certain that the average physician has known mighty little about the significance of abnormal conditions within the mouth. Both groups cannot help being benefited if they will take interest in these coming series of lectures.

It is highly proper right here that we should pay a compliment to the forward looking attitude of the dental group in this state. Their annual meetings have been of a high character for years and they have an increasingly large number of their members who are demonstrating that they want to be much more than narrow specialists. It is difficult for a specialist to take wide views. We cannot help but feel that in our own profession it is much more difficult than in the past when nearly all our specialists came up through general practice.

We hope many of our members will increase their breadth of vision by attending this seminar on Medical-Dental relations at Providence College.

DIABETES WEEK IN RHODE ISLAND

The report of the Committee on Diabetes of the Rhode Island Medical Society which appears elsewhere in this issue of the Journal deserves comment from several points of view. In the first place, it illustrates what can be accomplished by the planned and concerted effort of many individuals and agencies in a program whose objective is to improve the health of the public. The testing of urine samples from over seven thousand individuals is no mean undertaking and the discovery of 319 positive specimens, or 4.35 per cent of those tested, is a result that indicates beyond a doubt that the whole program was justified in terms of definite benefit to a very appreciable number of individuals. Just how many of those whose specimens showed positive tests for sugar were known diabetics under treatment it is impossible to say. It is certain, however, that many of these, by the very fact of the testing and the general emphasis on the importance of careful control, will be stimulated to return for

a better regimen under medical supervision. Besides those known diabetics who have made the all too common error of straying from the straight and narrow path of conscientious care of their diabetes, there were of course many in whom the positive test proved on careful check by their own physicians to be evidence of minor or transient glycosurias of non-diabetic origin, or to be due to the presence in the urine of some reducing substance other than glucose. To these people too the tests were of some value.

When, however, we have eliminated from consideration the known diabetics and those with positive tests proved to be of non-diabetic origin, we still have left the group of people for whose benefit "Detection Week" was initiated, the previously undetected true diabetics. How many of them there are, cannot be exactly determined, but probably from 100 to 200 at least. To each of them the discovery of the disease in its early stages will definitely mean the possibility of a longer and happier life and of the avoidance of those complications that occur when diabetes is allowed to reach a serious stage before treatment is instituted.

May we not also add that this project, carried out in Rhode Island and throughout the country, by the medical profession and its co-workers; nurses, pharmacists and the various other agencies noted in the report, is evidence that practitioners of medicine are among those whose interests lie not solely in "feathering their own nests" as it has recently become so popular to assert, but also, as the success of this drive has demonstrated, in putting forth considerable effort, individually and by collective planning, for the public good.

DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

Fifteen members attended the January 24, 1950 meeting of the Newport County Medical Society at the Newport Hospital. Dr. Philomen P. Ciarla, president, opened the meeting at 9:05 P.M.

The minutes of the previous meeting were read.

Dr. Samuel Adelson moved that the letters of condolence, prepared by Dr. Norman MacLeod, on the late Drs. Eugene A. McCarthy and John A. Young be spread on the minutes of this meeting and similar letters signed by the President and Secretary of the Newport County Medical Society and the President and Secretary of the Staff of the Newport Hospital be sent to the widows of these men. The letters follow:

Dr. Eugene A. McCarthy was selected to organize the Orthopedic Clinic at the Newport Hospital in 1913. He has continuously served this Clinic and this community since that time.

HENRY W. BROWNELL, M.D.
President, 1950
THE NEWPORT COUNTY MEDICAL SOCIETY

He has always maintained a high degree of skill and was alert in adopting the new procedures in his specialty.

He has also been a faithful member of the Newport County Medical Society.

The Staff of the Newport Hospital regret the loss of Dr. McCarthy who was at all times ready to contribute his time and his talents to the service of this community.

The Newport County Medical Society will miss their former associate of more than thirty years.

* * *

Dr. John A. Young started practice in Newport in 1906. In the more than forty years that he has served this community he has been noted for his thoroughness, his courtesy, and his devotion to his patients.

His association with the Hospital started in 1916 and as a member of the Medical Service he has contributed much to the practice of Medicine. He has served as President of the Staff and for many years has been a member of the Board of Censors of the Newport Medical Society.

In all his activities he has been a faithful and conscientious Practitioner and has always cooperated in every effort to improve the care and treatment of the patients.

The Staff of the Newport Hospital will miss this sterling physician and the Newport County Medical Society has lost a friend and co-worker who was always ready to carry his share of any responsibility.

* * *

Dr. John Malone moved that the President appoint a Medical Advisory Committee of three members of the Newport County Medical Society to the Newport County Red Cross Blood Program; That Dr. William Freeman be appointed as Medical Consultant and that Mr. William Turner be appointed as Administrative Consultant to the Medical Advisory Committee of the Newport County Medical Society. This was seconded and passed. Drs. Alfred M. Tartaglino, Frank Logler, and John M. Malone were appointed by the President for this committee.

A revised application form to the Society was approved except for the inclusion of admission

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NEWPORT COUNTY MEDICAL SOCIETY

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fee which will be considered when our By-Laws are revised this year.

The applications for membership of Drs. John E. Carey and Lorenzo Orlando were accepted and approved.

Dr. Samuel Adelson suggested that the Secretary write to the Secretary of State to determine if this Society is listed as a Corporation.

Dr. Samuel Adelson commented on Dr. Michael Sullivan's long service in Medicine and moved that the President appoint a committee of three with full power to arrange for a testimonial dinner in the near future to honor Dr. Sullivan's 50th year out of Medical School—his 49th in practice. Dr. Logler seconded and this was carried.

Dr. Henry Brownell moved that a one year subscription be taken to Marjorie Shearons "American Medicine and the Political Scene", and that this be presented to the Newport Hospital Library. This was seconded and passed.

The following men were elected to office for 1950.

President:	Dr. Henry W. Brownell
1st Vice President:	Dr. Robert L. Bestoso
2nd Vice President:	Dr. John M. Malone
Secretary:	Dr. Osmond Grimes
Treasurer:	Dr. Norbert V. Zielinski
Delegates:	Dr. Donald B. Fletcher
	Dr. Frank J. Logler
Councillor:	Dr. Samuel Adelson
Alternate Councillor:	Dr. Osmond Grimes
Censors:	Dr. Norman M. MacLeod
	Dr. George A. Eckert

The guest speaker, Charles Millard, M.D. of Barrington, R. I., spoke on the "Academy of General Practitioners" following which there was a considerable period of spirited discussion. Collation followed.

Respectfully submitted,
JOHN M. MALONE, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held on January 19, 1950, at 6:30 p.m. in the Nurses' Dining Room of Memorial Hospital. It was a supper meeting and twenty-three members were present.

The meeting was called to order by the President, Dr. John Gordon. The Secretary read the minutes of the previous meeting.

Dr. Robert Henry reported on the recent meeting of the House of Delegates during which physician directors of the Rhode Island Medical Society Physicians Service were nominated. Two members from the Pawtucket Medical Association, Dr. Earl Mara and Dr. Charles Farrell, were subsequently elected to the Board.

Dr. Charles L. Farrell, spoke briefly about the surgical-medical plan.

The meeting then adjourned to the Nurses' Auditorium where the speaker of the evening, Dr. Edwin B. Gammell, addressed the group on the subject "Hoarseness—Causes and Treatment." At the end of his talk Dr. Gammell presented a colored film depicting laryngeal lesions in an unusually lucid and satisfying demonstration, following which he introduced three of his patients on whom he had performed laryngectomies for Carcinoma. Listening to these patients with their esophogeal tones was a new experience to most of those present.

Dr. Rudolph Pearson of Providence spoke at some length about the speech classes held at the Rhode Island Medical Society Library. He also reported the encouraging results obtained in this type of lesion.

The meeting adjourned at 9:15 p.m.

Respectfully submitted,
KIERAN W. HENNESSEY, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, February 6, 1950. In the absence of the President, Dr. Ubaldo E. Zambarano, the meeting was called to order by Dr. Frank W. Dimmitt, Vice President, at 8:35 p.m.

The reading of the minutes of the previous meeting was omitted by consent of the members present.

Dr. Dimmitt reported a communication from the Medical Bureau of the Association calling to the attention of the members the fact that the new telephone directory would close within the month and therefore anyone desiring to have alternate listing with the Bureau should act promptly in the matter.

Dr. Dimmitt introduced as the first speaker of the evening Mr. S. Everett Wilkins, counsel for

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PROVIDENCE MEDICAL ASSOCIATION

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the Aetna Casualty and Surety Company, who gave a most interesting talk on "Legal Hazards of the Practice of Medicine." Dr. Roland Hammond, Chairman of the Medical Grievance Committee of the State Medical Society discussed Mr. Wilkins' paper. (The address by Mr. Wilkins is published in its entirety in this issue of the MEDICAL JOURNAL.)

The second speaker of the evening was Dr. Edward Scott O'Keefe, Pediatrician, Union Hospital, Lynn, Massachusetts, who spoke on "The Importance of Diet in the Treatment of Diarrhea in Infants." Dr. O'Keefe's paper was discussed by Dr. William P. Buffum and other members of the Association. (Dr. O'Keefe's talk is published in its entirety in this issue of the MEDICAL JOURNAL.)

Prior to adjournment at 9:55 p.m. Dr. Francis Chafee presented a motion that the Association extend its best wishes to its President, Dr. U. E. Zambarano for a speedy convalescence and early return to Providence, and the hope of the Association that he will be able to attend the next and succeeding meetings of the Association. The motion was seconded and unanimously adopted.

Attendance 88.

Collation was served.

Respectfully submitted,

JOHN E. FARRELL, Sc.D., *Executive Secretary*
in the absence of
DANIEL V. TROPPOLI, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Kent County Medical Society was held on Tuesday, January 17th at 1515 West Shore Road.

The meeting was called to order at 9:15 p.m. by President Dr. Joseph C. Kent.

The minutes of the last meeting were accepted as read.

Dr. John Mack, treasurer of the Society submitted a written annual report which was read to the members by the secretary. Dr. George Young moved that this report be accepted; seconded by Dr. Hardy and it was so voted.

Dr. George Young then reported that he accompanied Dr. Orland Smith to the local V.F.W. Post to talk to their members concerning the need of establishing a blood bank at the new Kent County Memorial Hospital. Considerable enthusiasm was rendered and support attained for this project. Dr. Young stated that a "spark was started" and will report on the progress at a later date.

It was also reported that the Warwick Kiwanis Club was interested in contributing some item; suggestion of an incubator was mentioned.

Application for membership from Dr. Russell Hager of 8 Post Road was received and approved by the board of censors. Vote taken and it was then moved by Dr. Taggart that the secretary cast one ballot; this was seconded by Dr. Hardy.

Following the business meeting, Dr. Rudolph Pearson was then introduced by the president. He delivered a very informative review of the etiology and management of "Headaches."

The meeting adjourned at 10:30 p.m.

Respectfully submitted,

E. T. HACKMAN, M.D., *Secretary*

CORRESPONDENCE

To The Editor:

I believe it is not generally known by the medical profession that there is a movement afoot to close Lakeside. This venerable institution which has served the community for many years is about to suffer because of insufficient operating funds from the Community Chest. Over its many years Lakeside has served as a convalescent home for underprivileged and malnourished children. For much of its existence, its activity was guided by the Providence Tuberculosis League. During this time the underprivileged and malnourished children of tuberculous parents were the principal beneficiaries of its activity. More recently underprivileged and malnourished children of many types and in increasing numbers were admitted. The community will screly miss the benefits of this necessary institution. If Lakeside does pass from the scene and this is the most likely result, some similar institution must be erected to fulfill the part which Lakeside has played. In spite of all of our good health procedures this community now and for many years will have underprivileged and malnourished children in need of convalescent supervision in a "Lakeside".

I would like to call upon Rhode Island physicians to express their views of the Lakeside closing.

PETER F. HARRINGTON, M.D.

BY-LAWS OF THE RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

(As Amended)

ARTICLE I
Membership of the Corporation

Section 1. The members of the Rhode Island Medical Society Physicians Service shall consist of (a) members of the House of Delegates of the Rhode Island Medical Society (as the same shall be from time to time constituted), (b) the incorporators of the Rhode Island Medical Society Physicians Service, (c) members of the Board of Directors of the Rhode Island Medical Society Physicians Service (as the same shall be from time to time constituted), and (d) such other persons, non-physicians, as may be elected to membership in the corporation by its Board of Directors; provided that non-medical members shall not constitute more than twenty per cent of the total membership of the corporation.

Section 2. Each member of the corporation shall be entitled to one vote.

ARTICLE II
Meetings

Section 1. The annual meeting of the members of the Rhode Island Medical Society Physicians Service shall be held in the month of January of each year on a day fixed by the Board of Directors, and at such place as the Board of Directors shall designate.

Section 2. Special meetings of the members may be called at any time by the President, and shall be called by him on written request of a majority of the directors or one third of the members of the corporation.

Section 3. Written notice of each meeting shall be mailed to the members at least five days, or telegraphed or delivered to each member at least forty-eight hours before the day appointed for the meeting at their last known address on the records of the corporation.

Section 4. At every meeting of the members there shall be represented in person at least twenty of the members to constitute a quorum, but a smaller number may adjourn from time to time.

ARTICLE III
Board of Directors

Section 1. The incorporators and such persons as they shall elect shall serve as the directors until the annual meeting of the members in January, 1950, at which time the Board of Directors shall be constituted as follows: Twelve Fellows of the Rhode Island Medical Society shall be nominated by the House of Delegates of said Society, four to hold office for a term of three years, four to hold office for a term of two years, and four to hold office for a term of one year, and thereafter annually four Fellows of the Society shall be nominated by the House of Delegates to hold office for a term of three years. Six directors, of whom two shall be nominated by the Hospital Service Corporation of Rhode Island, elected annually by the Board of Directors of the Rhode Island Medical Society Physicians Service to hold office until the next succeeding annual meeting of the members of the Rhode Island Medical Society Physicians Service, as representatives of the public.

Section 2. The Board of Directors shall have the power to select persons to fill vacancies in the Board, occurring during the year, who shall serve until the next annual meeting of the members.

Section 3. The Board of Directors shall have supervision and control of the business, property, affairs and management of the corporation, and without limiting the generality of the foregoing, shall elect the officers of the corporation; shall have authority to make rules and regulations for the conduct of affairs of the corporation, to decide the scope of services to be furnished subscribers and any conditions thereof, to adopt rates and indemnity schedules and enter into contracts for the rendering of all such services, to incur indebtedness in such amounts and under such terms and conditions as it shall deem necessary and proper, to invest and reinvest all money, funds and securities of the corporation, to create and conserve a reserve fund to be used for promoting the purposes of the corporation, and to delegate its powers to committees, officers, agents and representatives; and shall have such other powers as may be necessary or expedient to carry out the purposes of the corporation. The Board of Directors may employ such persons as it may deem necessary to assist the officers and the board to carry on the work of the corporation.

Section 4. The Board of Directors shall hold an annual meeting following the annual meeting of

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the members of the corporation, or any special meeting of the members held in lieu thereof. Regular meetings shall be held at such times and places as the board shall determine. Special meetings may be called at any time by the President, and shall be called by him on written request of at least one third of the directors.

Section 5. A majority of the directors shall constitute a quorum for a meeting of the Board of Directors. If at any meeting less than a quorum shall be present, a majority of those present may adjourn the meeting from time to time without notice. The action of a majority of the directors present at any meeting at which there is a quorum shall constitute the action of the Board of Directors.

Section 6. No compensation shall be paid to any director for services as director, but reimbursement for actual and reasonable expenses may be authorized by the Board.

ARTICLE IV
Committees

Section 1. The Board of Directors shall appoint annually four (4) standing committees—an Executive Committee, a Finance Committee, a Professional Advisory Committee, and a Joint Operations Committee. It may appoint such other committees as it may deem appropriate.

Section 2. The Executive Committee shall be composed of (5) directors. Three (3) members shall constitute a quorum of this committee. The Executive Committee shall be vested with such powers of the Board of Directors when the board is not in session as the board shall by resolution provide. It shall make a written report of its proceedings and action at the next succeeding meeting of the Board of Directors.

Section 3. The Finance Committee shall consist of three (3) directors. It shall have such financial duties and powers as may be given to it by the Board of Directors. One member of the Executive Committee shall be a member of the Finance Committee. The Finance Committee shall make a report of its transactions at the next succeeding meeting of the Board of Directors or Executive Committee.

Section 4. The Professional Advisory Committee shall consist of three (3) directors. In accordance with the general policy of the corporation and subject to the authority of the Board of Directors and the Executive Committee, the Professional Advisory Committee shall supervise arrangements with physicians concerning participation, fees, and the rendering of services according to the provisions of the medical service plan, and its determinations shall be binding and conclusive on the persons concerned. One member of the Executive Committee shall be a member of the Professional Advisory Committee.

Section 5. The Joint Operations Committee shall consist of three (3) directors. It shall carry out the functions set forth in the joint operations agreement between the Rhode Island Medical Society Physicians Service and the Hospital Service Corporation of Rhode Island, and such other functions as may be delegated to it from time to time by the Board of Directors. It shall make a written report of its proceedings and actions at the next succeeding meeting of the Board of Directors, or the Executive Committee.

ARTICLE V
Officers

Section 1. The officers of the corporation shall be elected annually by the Board of Directors and shall consist of a President, a Vice President, a Secretary, a Treasurer, and such Assistant Treasurers and Secretaries as the Board of Directors may deem appropriate. All of the said officers shall hold their respective offices for one year and thereafter until their successors are elected and qualified, except that the officers appointed at the first meeting of the corporation shall hold office until the first annual meeting and thereafter until their successors are elected and qualified. The President shall be chosen from among the directors of the corporation, but other officers need not be. The board may appoint such other officers and agents as it may deem necessary for the transaction of the business of the corporation, and all such officers and agents shall respectively have such authority and perform such duties as may be prescribed by the Board of Directors. Officers and agents may be paid such reasonable salaries or compensation as the Board of Directors shall determine.

Section 2. The President shall preside at all meetings of the members of the corporation and the Board of Directors; shall perform such duties as are required by law or which usually pertain to such office; and shall exercise such other powers and perform such other duties as may be assigned to him by the Board of Directors.

Section 3. The Vice President shall perform such duties as may be assigned by the Board of Directors, and he shall exercise the powers and perform the duties of the President in the absence or incapacity of the President.

Section 4. The Secretary shall record the minutes of all meetings of the members of the corporation and the Board of Directors; shall have the custody of the corporate seal, and in all proper cases shall affix the same to any instrument requiring the seal. The Secretary shall attend to the

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giving and receiving of all notices of the corporation, and shall perform such other acts as the Board of Directors may determine.

Section 5. The Treasurer shall have the care and custody of and be responsible for the funds and securities of the corporation. He shall direct the deposits in such bank or banks as the Board of Directors may designate, and shall disburse the funds in such manner as may be designated by the board. He shall keep proper vouchers and a complete record of receipts and disbursements. He shall make an annual report in writing on the finances of the corporation, and he shall make such other reports as may from time to time be required by the Board of Directors. He shall, if required by the Board of Directors, give bond in such form, in such sum and with such sureties as it may require.

Section 6. The Executive Director shall, under the direction of the Joint Operations Committee and the Board of Directors of the Rhode Island Medical Society Physicians Service, carry on the business of the corporation pertaining to all administrative functions as set forth in the joint operations agreement between this corporation and the Hospital Service Corporation of Rhode Island. He shall make such reports and attend such meetings as may be required by the Board of Directors.

Article VI
Execution of Papers

Except as the Board of Directors may generally or in particular cases authorize the execution thereof in some other manner, (1) all conveyances of real estate and leases shall be signed by the President or Treasurer; (2) all obligations for payment of money on sight, including checks and drafts, made or endorsed by the corporation, except when endorsed for deposit or collection, shall be signed by either the Treasurer or Assistant Treasurer; (3) all other obligations for the payment of money and all evidences of debt payable at a future time, including acceptances, notes and bonds, shall be signed by the Treasurer, and countersigned by either the President, Secretary or Vice President; and (4) no person holding more than one office in the corporation may sign, countersign or execute any paper in the capacity of more than one office so held in cases where two signatures are required.

Article VII
Subscribers

Section 1. Persons who respectively fulfill the qualifications specified by the Board of Directors shall be eligible as subscribers to the respective medical service plans. The Board of Directors shall adopt medical service certificates embodying such

terms and provisions as are deemed appropriate. The Board may specify the limits of the benefits to be furnished and may classify such benefits.

Section 2. Employers, societies, groups and other authorities or agencies may underwrite or contribute in full or in part to the costs of medical care for the benefit of employees, members or other persons who may become entitled to medical service under a medical service plan.

Section 3. The corporation shall not in any event or under any circumstances be liable for any act, negligence or failure to act by a physician in connection with medical care or services given or that should have been given to any persons.

ARTICLE VIII
Participating Physician

Section 1. Any physician or surgeon who is licensed to practice medicine or surgery under Section 3 of Chapter 275 of the General Laws of Rhode Island (1938), and who shall agree with the corporation to abide by the rules and regulations of the corporation may become a Participating Physician.

Section 2. Subject to the code of ethics of the American Medical Association, a Participating Physician shall have the right to accept or reject patients so far as subscribers are concerned and the right to discontinue treatment of any subscriber according to the code of ethics of the American Medical Association, provided, however, he shall not have the right to refuse to accept a subscriber as a patient or to continue treatment of a subscriber for the reason that he is a subscriber, and such refusal shall constitute grounds for the termination by the corporation of its agreement with a Participating Physician.

Section 3. A Participating Physician shall not request or accept from anyone whom he knows to be a subscriber within the eligible income groups specified by income limits established from time to time by the corporation any compensation for such services as such subscriber is entitled to under his contract with the corporation, except such charges, if any, as may be provided in the rules and regulations adopted by the Board of Directors and set forth in the subscription certificate or contract.

ARTICLE IX
Fiscal Year

The fiscal year of the corporation shall be the calendar year.

ARTICLE X
Miscellaneous

Section 1. The Board of Directors may adopt such rules and regulations as it may deem necessary,

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BOOK REVIEWS

MEDICAL STATE BOARD QUESTIONS AND ANSWERS. By R. H. Goepp, M.D. and Harrison F. Flippin, M.D. Eighth edition. Published by W. B. Saunders Company, 1950.

The eighth edition of this well-known and much utilized book on Medical State Board Questions and Answers appears to follow the style of the earlier editions.

Much additional material has been added to it, however, to keep it in line with the important contributions that have recently been made in the field of medicine, particularly in therapeutics.

In order to present the latest knowledge available Dr. Goepp secured the colaboration of Dr. Harrison F. Flippin, a physician especially well qualified by his clinical and teaching experience. With the exception of the section on anatomy which was completely revised in the preceding edition all sections have been rewritten and brought up to date and a new section on psychiatry has been added.

The new drugs and therapeutic procedures appear to be fairly well covered although in some instances it appears that more detailed descriptions would have increased the value of the book.

In spite of the fact that the Rhode Island Board of Examiners in Medicine does not obtain its examination material from this source, it appears that the book could serve as a valuable and useful means of review for candidates preparing for State Board examination.

JOHN A. BOLSTER, M.D., *Secretary*
State Board of Examiners in Medicine

OCCUPATIONAL MARKS AND OTHER PHYSICAL SIGNS: A GUIDE TO PERSONAL IDENTIFICATION. By Francesco Ronchese, M.D., Assistant Professor of Dermatology, Boston University School of Medicine, Boston. Cloth. Price $5.50, Pp. 181, with 151 illustrations. Grune & Stratton, Inc., 381 4th Ave., New York 16, 1948.

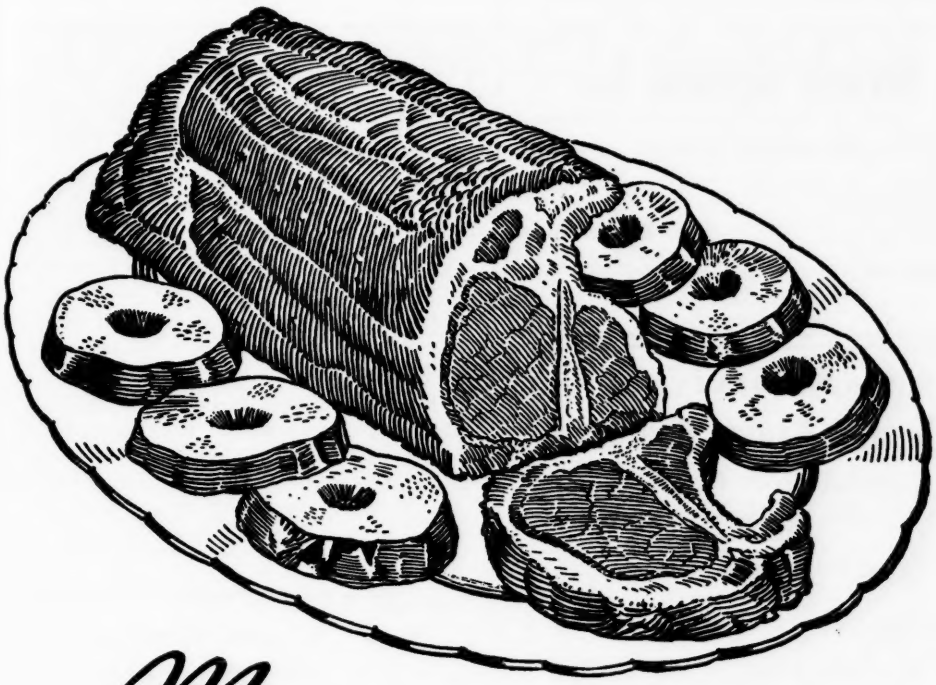
In his preface, the author states that the gathering of his data served "as a relaxation and welcome variation in the more routine aspects of practice." The reader of the composite of this data will, in turn, find it a relaxing and welcome variation from the more routine type of medical literature. Written in simple and straightforward style, and interspersed with humorous comments, it presents a verbal and pictorial account principally of those cutaneous marks characteristic of various occupations.

The book is divided into two main sections, the first descriptive and the second composed of photographs and sketches. The descriptive part is, in turn, divided into six chapters. The first briefly covers some general aspects of the subject and is essentially an introduction. The following section discusses specific occupational marks, ranging from the well-known "housemaid's knee" to the less familiar thin, painful calluses on the palms of glass blowers due to their holding heavy, hot, iron blowpipes. The chapter on professional markings reviews the characteristic findings among physicians, athletes, dancers and musicians. In the next section, distinctive markings are considered in terms of specific body areas. Of interest was the report that notching of the upper incisors, due to the habit of opening bobby pins with the teeth, is found in approximately 90 per cent of women. Pseudo occupation marks, that is, marks resembling those due to occupation but actually due to some other cause, and legal problems arising from them and from the true occupational stigmata are considered briefly. Examples, such as psoriasis of the knuckles resembling scrubwoman calluses, and a lesion of von Recklinghausen's disease in the center of one palm simulating a professional callus, are mentioned. A general classification of occupational marks on the basis of usefulness in personal identification is presented in the final chapter. The second main section, comprising two-thirds of the book, contains an excellent collection of photographs and sketches illustrating the marks referred to in the text.

Dr. Ronchese, as a result of many years of thorough and painstaking study of patients, has been able to gather a large series of occupational marks and other characteristic physical signs. Perhaps most frequently these were discovered solely as a result of the examination, the patient volunteering information only about the dermatosis elsewhere which was responsible for his seeing the author. Therefore, Dr. Ronchese emphasizes the necessity for a complete and careful examination of each patient, always viewing any observed mark in terms of the whole picture, and at all times being aware of the possibility of pseudo occupational stigmata.

This book, filled with a wealth of fascinating information, should prove of considerable interest to all physicians, to the criminologist, and to those concerned with the personal identification of the dead.

ARTHUR B. KERN, M.D.



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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (Apr. 2,) 1949

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expedient or proper to further the purposes of the corporation.

Section 2. The Board of Directors is vested with the authority to interpret and construe these by-laws and any rules and regulations which may be adopted by the board.

Section 3. The seal of the corporation shall contain the words "THE RHODE MEDICAL SOCIETY PHYSICIANS SERVICE" and the date of its incorporation, and shall be in such form as the Board of Directors may determine.

Section 4. The principal offices of the corporation shall be in the city of Providence in the State of Rhode Island.

Section 5. These By-Laws may be amended or altered at any meeting of the Board of Directors by the affirmative vote of two-thirds of the directors present, provided notice of the general character of the proposed amendment or alteration was contained in the notice of the meeting.

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